		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042028

Facility Name: ALDEN NORTH SHORE REHAB & HCC

Address: 5050 WEST TOUHY AVENUE (Number) SKOKIE (City) 60077 (Zip Code)

County: COOK

Telephone Number: (847) 679-6100 **Fax #** (847) 679-3822

IDPA ID Number: 36-3978207

Date of Initial License for Current Owners: 08/06/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JOAN CARL
(Title) VICE PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	342	2,415	16,442	19,199	8
9	SNF/PED					9
10	ICF	1,238	6,017	16	7,271	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,580	8,432	16,458	26,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.98%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/14/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/14/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 16,438

Medicare Intermediary ADMINISTAR FEDERAL, INC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	468,102	23,835		491,937	614	492,551		492,551			1
2	Food Purchase		236,549		236,549	(22,397)	214,152	2,540	216,692			2
3	Housekeeping	90,584	18,554		109,138	541	109,679		109,679			3
4	Laundry	42,259	16,736		58,995	158	59,153		59,153			4
5	Heat and Other Utilities			180,864	180,864		180,864	(4,013)	176,851			5
6	Maintenance	43,689		120,438	164,127	104	164,231	3,765	167,996			6
7	Other (specify):* Related Party Salary							20,628	20,628			7
8	**TOTAL General Services**	644,634	295,674	301,302	1,241,610	(20,980)	1,220,630	22,920	1,243,550			8
	B. Health Care and Programs											
9	Medical Director			87,000	87,000		87,000		87,000			9
10	Nursing and Medical Records	1,823,824	117,007	146,747	2,087,578	(62,988)	2,024,590	1,210	2,025,800			10
10a	Therapy	85,257			85,257		85,257		85,257			10a
11	Activities	80,139	4,509	7,725	92,373		92,373		92,373			11
12	Social Services	45,668			45,668		45,668		45,668			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							13,390	13,390			15
16	**TOTAL Health Care and Programs**	2,034,888	121,516	241,472	2,397,876	(62,988)	2,334,888	14,600	2,349,488			16
	C. General Administration											
17	Administrative	79,382			79,382		79,382		79,382			17
18	Directors Fees											18
19	Professional Services			848,016	848,016		848,016	(349,099)	498,917			19
20	Dues, Fees, Subscriptions & Promotions			55,305	55,305	(5,524)	49,781	(43,812)	5,969			20
21	Clerical & General Office Expenses	250,487	20,551	79,359	350,397	4,396	354,793	(84,589)	270,204			21
22	Employee Benefits & Payroll Taxes			398,313	398,313	17,516	415,829	(12,874)	402,955			22
23	Inservice Training & Education					65,250	65,250		65,250			23
24	Travel and Seminar			3,096	3,096	1,250	4,346	7,654	12,000			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,779	102,779		102,779	10,336	113,115			26
27	Other (specify):* Related Party Salary/Bad Debt Expense			3,596	3,596		3,596	218,395	221,991			27
28	**TOTAL General Administration**	329,869	20,551	1,490,464	1,840,884	82,888	1,923,772	(253,989)	1,669,783			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,009,391	437,741	2,033,238	5,480,370	(1,080)	5,479,290	(216,469)	5,262,821			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC #0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,667	59,667		59,667	210,764	270,431			30
31	Amortization of Pre-Op. & Org.							5,730	5,730			31
32	Interest			278,589	278,589		278,589	470,332	748,921			32
33	Real Estate Taxes							213,360	213,360			33
34	Rent-Facility & Grounds			1,030,915	1,030,915		1,030,915	(1,030,915)				34
35	Rent-Equipment & Vehicles			11,142	11,142		11,142	13,063	24,205			35
36	Other (specify):* MIP & Amort							75,829	75,829			36
37	TOTAL Ownership			1,380,313	1,380,313		1,380,313	(41,837)	1,338,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		861,495	1,204,977	2,066,472	1,080	2,067,552	(8,115)	2,059,437			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,919	50,919		50,919		50,919			42
43	Other (specify):* Day Training Costs			49	49		49		49			43
44	TOTAL Special Cost Centers		861,495	1,255,945	2,117,440	1,080	2,118,520	(8,115)	2,110,405			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,009,391	1,299,236	4,669,496	8,978,123		8,978,123	(266,421)	8,711,702			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(56)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(58,375)	30		9
10	Interest and Other Investment Income	(393)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,928)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(667)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,793)	20		19
20	Contributions	(20)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,898)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,596)	27		24
25	Fund Raising, Advertising and Promotional	(40,582)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,308)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	71,018	Various	34
35	Other- Attach Schedule	(212,131)	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (141,113)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (266,421)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN NORTH SHORE REHAB & HCC

ID# 0042028

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Valet Cost (GL 6907)	$ (34,339)	21	1
2	Late Fees on Utilities	(5,389)	5	2
3	Late Fees on Telephone (GL 6843)	(35)	21	3
4	Intercompany Interest (GL 7031)	(64,320)	32	4
5	Intercompany Interest (GL 7053)		32	5
6	Misc Income from Payroll Dept(GL 4977)	(337)	22	6
7	Marketing Manager (GL 6701-100-009)	(94,728)	21	7
8	Back Out Vendor Settlement for prior year (GL 7143)	3,588	21	8
9	Adj Depreciation to actual	2,445	30	9
10	Adj Deferred Maint Deprec to actual	(618)	6	10
11	Back out % of Employee Benefits for Mktg Mgr	(12,538)	22	11
12	Back out 32.97% of PAC fees from standard ILHCA bill	(1,693)	20	12
13	Back Out Vendor Settlement for prior year (GL 7143)	(3,588)	19	13
14	Misc Income from Accts Rec Dept(GL 4977)	(410)	21	14
15	Misc Income from Medical Records AR Dept(GL 4977)	(170)	10	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(212,131)		49

Reporting Period Beginning 1/1/2005
Reporting Period Ending 12/31/2005

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description			
22		(4,881)	Uniforms			
	1	614	Uniforms			
	3	541	Uniforms			
	4	158	Uniforms			
	6	104	Uniforms			
	10	3,342	Uniforms			
	21	122	Uniforms			
2		(22,397)	Employee Meal			
	22	22,397	Employee Meal			
10		(1,080)	Oxygen	1,129.80		sum of GL's 4341 (100-PA, 100-VD, 100-CR)
	39	1,080	Oxygen	23,310.00	0.048	Total Oxygen Rev (sum of all 4341 accts)
					22,281.05	Account 5341
10		(65,250)	Dart Chart Fees		1,079.93	
	23	65,250	Dart Chart Fees			
		0.00	**Net should be 0**			

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,984)	0	0	4,524	0	0	0	0	0	0	0	2,540	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,389)	0	1,376	0	0	0	0	0	0	0	0	(4,013)	5
6	Maintenance	(618)	0	4,098	0	0	0	285	0	0	0	0	3,765	6
7	Other (specify):*	0	0	20,628	0	0	0	0	0	0	0	0	20,628	7
8	**TOTAL General Services**	(7,991)	0	26,102	4,524	0	0	285	0	0	0	0	22,920	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(170)	0	0	3,834	(2,454)	0	0	0	0	0	0	1,210	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	13,390	0	0	0	0	0	0	0	0	13,390	15
16	**TOTAL Health Care and Programs**	(170)	0	13,390	3,834	(2,454)	0	0	0	0	0	0	14,600	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,486)	379,289	(706,902)	0	0	0	0	0	0	0	0	(349,099)	19
20	Fees, Subscriptions & Promotions	(44,088)	0	276	0	0	0	0	0	0	0	0	(43,812)	20
21	Clerical & General Office Expenses	(126,591)	0	14,456	10,257	17,289	0	0	0	0	0	0	(84,589)	21
22	Employee Benefits & Payroll Taxes	(12,874)	0	0	0	0	0	0	0	0	0	0	(12,874)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,654	0	0	0	0	0	0	0	0	7,654	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,221	115	0	0	0	0	0	0	0	0	10,336	26
27	Other (specify):*	(3,596)	0	187,257	15,179	19,555	0	0	0	0	0	0	218,395	27
28	**TOTAL General Administration**	(208,635)	389,510	(497,144)	25,436	36,844	0	0	0	0	0	0	(253,989)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(216,796)	389,510	(457,652)	33,794	34,390	0	285	0	0	0	0	(216,469)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(55,930)	256,798	8,035	0	1,861	0	0	0	0	0	0	210,764	30
31	Amortization of Pre-Op. & Org.	0	4,990	740	0	0	0	0	0	0	0	0	5,730	31
32	Interest	(64,713)	495,390	32,285	0	3,249	4,121	0	0	0	0	0	470,332	32
33	Real Estate Taxes	0	209,079	3,010	0	1,271	0	0	0	0	0	0	213,360	33
34	Rent-Facility & Grounds	0	(1,030,915)	0	0	0	0	0	0	0	0	0	(1,030,915)	34
35	Rent-Equipment & Vehicles	0	0	13,063	0	0	0	0	0	0	0	0	13,063	35
36	Other (specify):*	0	75,829	0	0	0	0	0	0	0	0	0	75,829	36
37	**TOTAL Ownership**	(120,643)	11,171	57,133	0	6,381	4,121	0	0	0	0	0	(41,837)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(187,118)	(110,633)	289,636	0	0	0	0	0	(8,115)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(187,118)	(110,633)	289,636	0	0	0	0	0	(8,115)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(337,439)	400,681	(400,519)	(153,324)	(69,862)	293,757	285	0	0	0	0	(266,421)	45

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE PG 6K		SEE PG 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 1,030,915	NorthShore Associates, LLC		$	$ (1,030,915)	1
2	V	32	Interst Income - RR	2,135	NorthShore Associates, LLC			(2,135)	2
3	V	32	Interest - Misc	173,037	NorthShore Associates, LLC			(173,037)	3
4	V	19	Accounting Fees		NorthShore Associates, LLC		4,200	4,200	4
5	V	19	Misc Admin Expense		NorthShore Associates, LLC		375,089	375,089	5
6	V	33	Real Estate Tax		NorthShore Associates, LLC		209,079	209,079	6
7	V	26	Property & Liab Insur		NorthShore Associates, LLC		10,221	10,221	7
8	V	32	Interest on Mortgage Note		NorthShore Associates, LLC		670,562	670,562	8
9	V	36	Mortgage Insur Premium		NorthShore Associates, LLC		75,829	75,829	9
10	V	32	Late Charges on Mortgage		NorthShore Associates, LLC				10
11	V	32	Prepayment Penalty on Debt		NorthShore Associates, LLC				11
12	V	30	Depreciation		NorthShore Associates, LLC		256,798	256,798	12
13	V	31	Amortization		NorthShore Associates, LLC		4,990	4,990	13
14	Total			$ 1,206,087			$ 1,606,768	$ * 400,681	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	Professional Fees	$ 714,523	Alden Management Services		$ 7,621	$ (706,902)	15
16	V		21	General & Admin		Alden Management Services		14,456	14,456	16
17	V		5	Utilities		Alden Management Services		1,376	1,376	17
18	V		6	Maintenance		Alden Management Services		4,098	4,098	18
19	V		24	Auto/Travel/Seminars		Alden Management Services		7,654	7,654	19
20	V		26	Insurance		Alden Management Services		115	115	20
21	V		20	Dues & Subscriptions		Alden Management Services		276	276	21
22	V		30	Depreciation		Alden Management Services		8,035	8,035	22
23	V		31	Amortization		Alden Management Services		740	740	23
24	V		33	Real Estate Tax		Alden Management Services		3,010	3,010	24
25	V		35	Rent-Equip/Vehicles		Alden Management Services		13,063	13,063	25
26	V		32	Interest		Alden Management Services		32,285	32,285	26
27	V		7	Salaries-General Serv		Alden Management Services		20,628	20,628	27
28	V		15	Salaries-Health Care		Alden Management Services		13,390	13,390	28
29	V		27	Salaries-Gen Admin		Alden Management Services		187,257	187,257	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 714,523			$ 314,004	$ * (400,519)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consultant	$	Prism Health Care		$	$	15
16	V	7	Dietary Sal & Wages		Prism Health Care				16
17	V	2	Tube Feeding	310	Prism Health Care		4,834	4,524	17
18	V	10	Equipment Rental - Patient Care	3,060	Prism Health Care		6,894	3,834	18
19	V	39	Ancillary Supplies	242,467	Prism Health Care		55,349	(187,118)	19
20	V	39	Ancillary Vent Rentals		Prism Health Care				20
21	V	27	Gen'l & Admin Salaries		Prism Health Care		15,179	15,179	21
22	V	21	Gen'l & Admin Expenses		Prism Health Care		10,257	10,257	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 245,837			$ 92,513	$ * (153,324)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	Drugs	$ 327,258	Forum Extended CareWII	0.00%	$ 465,764	$ 138,506	15
16	V		10	House Stock	3,343	Forum Extended CareWII		2,965	(378)	16
17	V		39	IV	291,753	Forum Extended CareWII		42,618	(249,135)	17
18	V		39	Wound Vac	17	Forum Extended CareWII		13	(4)	18
19	V		21	Gen'l & Admin		Forum Extended CareWII		17,289	17,289	19
20	V		32	Interest		Forum Extended CareWII		3,249	3,249	20
21	V		33	Real Estate Tax		Forum Extended CareWII		1,271	1,271	21
22	V		30	Depreciation		Forum Extended CareWII		1,861	1,861	22
23	V		27	Gen'l & Admin Salary		Forum Extended CareWII		19,741	19,741	23
24	V		10	Pharmacy Consulting	16,172	Forum Extended CareWII		14,096	(2,076)	24
25	V		27	Employee Vaccin	855	Forum Extended CareWII		669	(186)	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 639,398			$ 569,536	$ * (69,862)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 1,149,104	Community Physical Therapy	100.00%	$ 1,438,740	$ 289,636	15
16	V	32	Interest		Community Physical Therapy		4,121	4,121	16
17	V	31	Amortization		Community Physical Therapy				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,149,104			$ 1,442,861	$ * 293,757	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	Repairs & Maintenance	$ 12,142	Alden Bennet Contruction		$ 12,427	$ 285	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 12,142			$ 12,427	$ * 285	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NURSING CENTER - NORTH SHORE # 004-2028 Report Period Beginning 01/01/05 Ending: 12/31/05

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
ANC Waterford	Aurora
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governer's Park of Barrington	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES			
Name	City	Type of Business	
The Forum Prof. Center	Chicago	Office rental	
Prism Health Care	Chicago	Nursing supplies	
Forum Extended Care II	Chicago	Pharmacy	
Alden Management	Chicago	Management	
Alden Estates of Evanston	Evanston	Assisted living	
Community Physical Therapy	Wood Dale	Therapy provider	
Courts of Waterford	Aurora	Alzheimers unit	
Gardens of Waterford	Aurora	Assisted living	

INVESTOR LIST AND PERCENTAGES
AS OF MARCH 11, 2004

	16,500
NAME	**NS**
STUART GOLDSAND	3
JULIAN BAILES MD	2
AARON CARL	2
LU SEZENOV	4
MILDRED SCHLOSSBERG	4
RONALD EATON	3
JOHN VERCILLO	3
BRETT CARL	1
LARRY SAUNDERS	1
FLOYD A. SCHLOSSBERG (*5% Split between Randi/Lauren/Audra -	27
FAS OF PTN	
FAS OF CORP	
AMS OF PTN (FAS OWNS 'S" CORP	
JOAN/SAM CARL (*5.5% Split - 1 each Hannah, Harry, Chloe, Alex; 3/4% each Pam and Rob)	13
WILLIAM HOLWAY	2
RICHARD KERN	2
RICHARD KERN TRUST	
RITCHIE SCHULLO IRA	1
RITCHIE SCHULLO	2
RANDI SCHULLO	2
RICHARD GOLDSAND TO SG 9/15/03	
ELLEN FRYMIRE	
JUDGE JULIAN BAILES	
JAMES FREY	
JACK & MARILYN FRYMIRE	
BRUCE JOHNSON	
AUDRA ELISCO	1
BRIAN KRAMER	
AMI PISSETZKY	LOAN 1
JOSEPH AMENT	1
GLORIA FISCH	
ROBERT MOLITOR	LOAN 1/2
DAVID MENN	1
STEVEN KRAMER	
RAYMOND & DARLENE SCHULTZ	
MARY CHELOTTI-SMITH	1/2
HERSHEL HERRENDORF	3
M. HEATHER BUSHONG	
RICHARD DONCHIN	
JOSHUA HERRENDORF	1
DON NADICK	
HARVEY & MARCIA BRIN	1
LAUREN & TERRY MAGNUSSION	1
CHARLES GIGER	
JAMES GIGER	
DOMINIC & CONCETTA SCHULLO	1
STUART & CAROLINE PALMER	1
JAMES HALLBERG	3
JAMES HALLBERG TRUST	
SCOTT CASTY	10
JOSEPH GARCIA	2
DR. GEORGE RICH	
ALVIN LEWITAS	
HAROLD SCALES	
ELLIOTT SLUTZKY	
ANGIE & DOMINICK BUSCEMI	
ROBERT & DEANNA CARAS	
RONALD & ANNETTE CARAS	
LISA & JEFFREY DELDIN	
ROSS DEUTSCH	
JAMIE GOLDSAND-SULLIVAN	
KENNETH & JERRI SUE GOLDSAND	
TERI HALL	
ROBERT HAWORTH	
GARY & PAULA LEV	
DAVID SABIN	
SUSAN SCHWARTZ	
M. MASON	
E. SCHULZ	
G. COHEN	
NOAM KEREM	
DAN DENISE	
TOTALS	100

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg a.	President	Chief Executive	27.00	136,270	0.928	2.32	salary	$ 3,230	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	1.00	74,000	0.928	2.32	salary	1,754	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	50,308	0.928	2.32	salary	1,192	7-7	3
4	Joan Carl d.	Secretary	Vice-President	7.50	136,270	0.928	2.32	salary	3,230	27-7	4
5	see others attached on page 7A			2.00							5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	$ 9,406		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Summary…										2
3	Ami Pissetzki	finance relations	invest/bank	1.00	136,270	0.928	2.32	Salary	3,230	27-7	3
4	Bob Molitor	Vp of Operations	operations	0.50	151,412	0.928	2.32	Salary	3,588	27-7	4
5	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	295,469	0.928	2.32	Salary	7,002	27-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,820		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc
Street Address: 4200 W Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE PG. 8A (Aslo on PG. 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	$42,694.00	08/01/05	$ 8,388,000	$ 8,368,076	07/31/45	5.4000	$ 483,252	1
2	Cambridge		X	Oper Loss Loan	$16,822.00	04/01/03	3,098,700	3,025,334	08/31/39	5.6900	187,308	2
3	Bank Leumi		X	LOC	$15,000.00	06/01/05	1,200,000	1,184,343	06/01/06	varies	41,234	3
4												4
5												5
	Working Capital											
6	Related Party-AMS	X		Working Capital							32,285	6
7	Related Party-CPT	X		Working Capital							4,121	7
8	Related Party-FECII	X		Working Capital							3,249	8
9	TOTAL Facility Related				$74,516.00		$ 12,686,700	$ 12,577,753			$ 751,449	9
	B. Non-Facility Related*											
10	Offset interest expense with NS Assoc's interest income										(2,135)	10
11	Offset interest expense with Corp's interest income										(393)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,528)	14
15	TOTALS (line 9+line14)						$ 12,686,700	$ 12,577,753			$ 748,921	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 75,829** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC **#** 0042028 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	213,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	208,042	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,258)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	214,337	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	209,079	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	130,432	8
	2001	129,328	9
	2002	190,237	10
	2003	207,104	11
	2004	208,042	12

2005 Accrual is based on 103% of 2004 paid tax invoices

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN NORTH SHORE REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3743

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-021-0000	Nursing Home Facility	$ 20,131.18	$ 20,131.18
2.	10-28-429-027-0000	Nursing Home Facility	$ 16,430.52	$ 16,430.52
3.	10-28-429-026-0000	Nursing Home Facility	$ 20,079.89	$ 20,079.89
4.	10-28-429-025-0000	Nursing Home Facility	$ 20,079.89	$ 20,079.89
5.	10-28-429-024-0000	Nursing Home Facility	$ 20,079.89	$ 20,079.89
6.	10-28-429-020-0000	Nursing Home Facility	$ 20,131.18	$ 20,131.18
7.	10-28-429-019-0000	Nursing Home Facility	$ 20,276.24	$ 20,276.24
8.	10-28-429-018-0000	Nursing Home Facility	$ 20,266.12	$ 20,266.12
9.	10-28-429-017-0000	Nursing Home Facility	$ 5,591.97	$ 5,591.97
10.	10-28-429-015-0000	Nursing Home Facility	$ 2,745.79	$ 2,745.79
		TOTALS	$ 165,812.67	$ 165,812.67

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN NORTH SHORE REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3743

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-016-0000	Nursing Home Facility	$ 2,020.77	$ 2,020.77
2.	10-28-429-022-0000	Nursing Home Facility	$ 20,113.40	$ 20,113.40
3.	10-28-429-023-0000	Nursing Home Facility	$ 20,095.16	$ 20,095.16
4.	Support Attached (pages)	Related Party-Alden Management	$ 130,007.00	$ 3,010.00
5.	Support Attached (pages)	Related Party-Forum	$ 15,792.00	$ 1,271.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 188,028.33	$ 46,510.33

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	34,483	1997	$ 955,797	1
2					2
3	TOTALS	34,483		$ 955,797	3

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 14,541	$	25	$	$	$ 14,541	4
5											5
6	93		1999	1999	6,782,967	195,977	40	169,574	(26,403)	1,017,444	6
7											7
8											8
	Improvement Type**										
9	draper corp-electric screen			1999	1,252	125	10	125		793	9
10	dakota wiring & comm.-wiring for cable tv			1999	2,500	250	10	250		1,563	10
11	climate serv-repair compressor			1999	1,990	133	15	133		807	11
12	tci cable-install cable			1999	1,254	125	10	125		773	12
13	ABC-install tiles/repair			2000	4,011	267	15	267		1,560	13
14	ABC-mainten-various/construction			2000	5,000	500	10	500		2,917	14
15	ABC-mainten-various/construction			2000	10,000	1,000	10	1,000		5,750	15
16	ABC-mainten-various/construction			2000	10,000	1,000	10	1,000		5,667	16
17	new horizons-phone system			2000	5,744	574	10	574		3,303	17
18	new horizons-phone system & cable			2000	2,784	278	10	278		1,578	18
19	new horizons-phone system			2000	3,742	374	10	374		2,120	19
20	dbs contract.-lawn sprinkler system			2000	1,611	107	15	107		591	20
21	ABC-misc construction work			2000	5,347	891	5	891		5,347	21
22	ABC-misc construction work			2000	13,118	2,405	5	2,405		13,118	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02			2001	3,361	336	10	336		1,344	23
24	Laport (walk off mat carpet/floor covering)			2001	3,548	710	5	710		2,957	24
25	The Floor Source (PT carpet/floor covering)			2001	1,576	315	5	315		1,287	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover			2001	289,721	19,315	15	19,315		96,574	26
27	New Horizon (phone system)			2001	1,256	126	10	126		523	27
28	ABC-misc construction work			2002	19,580	1,305	15	1,305		5,221	28
29	ABC-misc construction work			2002	6,706	447	15	447		1,788	29
30	ABC-misc construction work			2002	16,368	1,091	15	1,091		4,365	30
31	ABC-misc construction work			2003	2,116	212	10	212		635	31
32	GT Mechanical-repair exhaust fans			2003	6,080	608	10	608		1,621	32
33	EWS-repair opxyen alarm ssytem			2003	2,054	411	5	411		1,027	33
34	ABC-parking lot upgrades			2003	7,538	753	10	753		1,885	34
35	ABC-parking lot repairs			2003	2,943	589	5	589		1,472	35
36											36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GT Mechanical-thermostat equip	2004	1,693	169	10	169		$ 339	37
38	ABC-repair sewer	2004	19,580	1,958	10	1,958		3,427	38
39	GT Mechanical-misc repairs	2004	1,442	288	5	288		481	39
40	GT Mechanical-replace pump	2004	2,496	499	5	499		790	40
41	GT Mechanical-misc repairs	2004	614	123	5	123		195	41
42	ABC-bath,plumb. Upgrade	2004	1,813	181	10	181		287	42
43	ABC-painting supplies	2004	1,258	252	5	252		377	43
44	GT Mechanical-Electric improvement	2004	917	92	10	92		122	44
45	ABC-plumbing/misc. repairs	2004	3,971	397	10	397		496	45
46	CAPPS Plumb.-ceiling repair	2004	1,480	148	10	148		160	46
47	TopNotch-motor drive repair	2004	3,139	314	10	314		340	47
48	ABD- carpet repairs	2004	4,943	494	10	494		535	48
49	ABC-misc repairs	2004	2,783	398	7	398		696	49
50	ABC parking lot improve.	2004	16,008	1,601	10	1,601		2,001	50
51	ABC-Tile and Grout Restoration	2005	7,830	522	10	522		706	51
52	GT Mechanical-AC Repair	2005	7,064	706	10	706		183	52
53	ABC-Cabinetry	2005	4,393	183	15	183		161	53
54	Long Elevator-Replace Motor	2005	3,860	161	5	161		57	54
55	Long Elevator-Replace Mechanic Starter	2005	1,530	57	5	57		89	55
56	Patten CAT-Repair Generator	2005	2,074	78	20	78		78	56
57	GT Mechanical-No AC Water/Temp Low	2005	1,340	89	10	89		210	57
58	ABC-Asphalt Maintenance	2005	6,045	210	12	210		187	58
59	GT Mechanical-3 new motors, motor brackets, and fan blades	2005	4,497	187	10	187		321	59
60	ABC-Fabricate and install elevator finishes	2005	12,843	321	10	321		522	60
61	ABC-misc construction work	2005	(19,580)	(1,305)	15	(1,305)		(5,221)	61
62	ABC-misc construction work	2005	(6,706)	(447)	15	(447)		(1,788)	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	1
2									2
3									3
4									4
5									5
6									6
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	4
5	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	5
6	Leasehold Improvement-Tenant Improvemen	1987	893		13			893	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,203	200	16	200		2,204	8
9	Leasehold Improvement-Build.Improv	1996	1,129	71	16	71		702	9
10	Leasehold Improvement-Asphalting	2000	88		3			88	10
11	Leasehold Improvement-DAI	2001	154	15	10	15		64	11
12	Leasehold Improvement-Bathrooms	2002	667	76	7	76		242	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		491	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, et	2004	1,801	329	7	329		465	14
15	Leasehold Improvement-Add-on Improvement, fixture bas	1980	71		23			71	15
16	Leasehold Improvement-Add-on Improvement, lighting bas	2001	123	25	5	25		117	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		1,997	28
29	Leasehold Improvement-Remodeling	2003	5,085	726	7	726		2,072	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306		2,139	33
34	TOTAL (lines 1 thru 33)		$ 7,397,270	$ 240,507		$ 214,104	$ (26,403)	$ 1,264,462	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	1
2									2
3									3
4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,316,034	$ 237,900		$ 211,497	$ (26,403)	$ 1,204,322	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 544,687	$ 76,652	$ 44,680	$ (31,972)	various	$ 358,497	71
72	Current Year Purchases	24,540	1,961	1,961		various	1,961	72
73	Fully Depreciated Assets	76,239	2,218	2,218		various	76,239	73
74								74
75	TOTALS	$ 645,466	$ 80,831	$ 48,858	$ (31,972)		$ 436,696	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party - AMS	various/van	1998-2004	$ 4,706	$ 111	$ 111	$	3	$ 4,638	76
77	Bus-van	01 Bus	01	49,826	9,965	9,965		5	49,826	77
78										78
79										79
80	TOTALS			$ 54,532	$ 10,076	$ 10,076	$		$ 54,464	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,971,829	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 328,807	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,431	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (58,375)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,695,482	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NA	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ NA	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled Nurses on Site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party-Cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 03/01/2000
Ending 12/31/2039

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 791,604
13.	/2007	$ 791,604
14.	/2008	$ 791,604

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 10,861 Description: Copy Machine Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related party - AMS		$ #######	$ 13,063	17
18	Various Auto lease charges		23.42	281	18
19					19
20					20
21	TOTAL		$ #######	$ 13,344	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 419,325	$		$ 419,325	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			49,134			49,134	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			680,645			680,645	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See PG 16A	# of prescrpts				216,625		216,625	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See PG 16A				289,636	404,072		693,708	13
14	TOTAL			$		$ 1,438,740	$ 620,697		$ 2,059,437	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

ALDEN NORTHSHORE REHAB & HCC
Page 16A
2005

		Page 16 Col 5: PT,OT, & ST Col 6: Other Amount
XIV. SPECIAL SERVICES (Direct Cost)		
Service		
1. OT	39-3	419,325
2. ST	39-3	49,134
3.		
4. PT	39-3	680,645
5.		
6.		
7.		
8.		
9. Phamacy	See pg 16A	327,258
Plus: Related Party- Forum Drugs		138,506
Plus: Related Party- Forum I.V.		(249,135)
Plus: Related Party- Wound Vac		(4)
Total to line 9 Pharmacy		216,625
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	-
12. Exceptional Care-Column 6	See pg 16A	-
13.Other : Lab,x-ray therapy,Mattress,Pyramid billings		590,110
Related Party- Prism		(187,118)
Related Party- CPT	**Col 5---->**	289,636
Oxygen Costs-IDPA		1,080
Total to line 13		693,708
14. Total		2,059,437

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (96,531)	$ (96,652)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,000)	1,257,978	1,257,978	3
4	Supply Inventory (priced at)	537	537	4
5	Short-Term Investments		3,025,334	5
6	Prepaid Insurance		36,742	6
7	Other Prepaid Expenses	2,066	2,066	7
8	Accounts Receivable (owners or related parties)	1,803,042	1,721,840	8
9	Other(specify): Due from 3rd parties	49,161	49,161	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,016,253	$ 5,997,006	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,839,086	14
15	Leasehold Improvements, at Historical Cost	522,991	522,991	15
16	Equipment, at Historical Cost	179,635	1,091,942	16
17	Accumulated Depreciation (book methods)	(283,587)	(1,909,105)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,343	307,074	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(14,269)	(24,228)	20
21	Restricted Funds		670,913	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 431,113	$ 9,454,470	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,447,366	$ 15,451,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,970,196	$ 2,063,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,115	88,115	28
29	Short-Term Notes Payable	1,184,343	1,184,343	29
30	Accrued Salaries Payable	291,525	291,525	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,623	15,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)		214,300	32
33	Accrued Interest Payable	7,782	59,783	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Exp, IDPA, Misc	201,632	459,231	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,759,216	$ 4,376,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,996,513	2,996,513	39
40	Mortgage Payable		11,300,940	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,996,513	$ 14,297,453	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,755,729	$ 18,673,789	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,408,363)	$ (3,222,313)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,347,366	$ 15,451,476	48

***(See instructions.)**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,990,157)	1
2	Restatements (describe):		2
3	**external audit adjustments made after 2004 cost report was**		3
4	**submitted. These have no effect on prior years report:**	(4,604)	4
5	**Bad debt, Medicare revenues (non-allowables)**		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,994,761)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	586,398	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 586,398	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,408,363)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,397,829	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,397,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	104,399	6
7	Oxygen	3,736	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 108,135	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	79	12
13	Barber and Beauty Care	1,541	13
14	Non-Patient Meals	56	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,653	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(7,299)	19
20	Radiology and X-Ray	5,440	20
21	Other Medical Services	52,074	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,544	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	393	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 393	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	916	28
28a	Prior year account adjustments	1,704	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,621	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,564,521	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,241,610	31
32	Health Care	2,397,876	32
33	General Administration	1,840,884	33
	B. Capital Expense		
34	Ownership	1,380,313	34
	C. Ancillary Expense		
35	Special Cost Centers	2,066,521	35
36	Provider Participation Fee	50,919	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,978,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	586,398	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 586,398	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,832	2,960	$ 118,655	$ 40.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,976	25,356	768,947	30.33	3
4	Licensed Practical Nurses	5,292	5,519	131,991	23.92	4
5	CNAs & Orderlies	52,612	54,397	699,517	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,016	2,080	26,361	12.67	8
9	Activity Director	2,072	2,080	33,898	16.30	9
10	Activity Assistants	6,060	6,344	78,410	12.36	10
11	Social Service Workers	1,952	2,080	45,668	21.96	11
12	Dietician					12
13	Food Service Supervisor	2,155	2,267	58,646	25.87	13
14	Head Cook	5,720	6,176	86,304	13.97	14
15	Cook Helpers/Assistants	29,137	31,164	323,152	10.37	15
16	Dishwashers					16
17	Maintenance Workers	1,984	2,080	43,689	21.00	17
18	Housekeepers	9,351	10,336	90,584	8.76	18
19	Laundry	5,024	5,257	42,259	8.04	19
20	Administrator	2,000	2,080	79,382	38.16	20
21	Assistant Administrator					21
22	Other Administrative	5,680	6,240	177,228	28.40	22
23	Office Manager	1,816	1,953	30,722	15.73	23
24	Clerical	2,862	2,868	25,369	8.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,446	2,486	72,545	29.18	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Clinical Sup Super	1,746	1,842	58,896	31.97	32
33	Other(specify) Volunteer Coord	720	855	17,168	20.08	33
34	TOTAL (lines 1 - 33)	167,453	176,420	$ 3,009,391 *	$ 17.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	7250/mon	87,000	1-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/mon	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,688	11-3	44
45	Social Service Consultant	4	828	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	$ 92,748		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ NA		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Schullo, J	Administrator	0	$ 79,382
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,382

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management	Management Fees	$ 714,523
Barry H Greenburg, Ken Fisch	Legal Fees Non Collections	11,473
Schmidt Salzman & Moran	Real Estate Tax Appeals	3,147
AMS	Professional Fees	1,220
SMS	Billing Consultant	3,159
BDO / AMS	Accounting Fees	5,682
Clausen Miller PC, Ailen Babayan	Legal Fees Non Collections	6,268
Ken Fisch	Legal Fees Collections	10,195
Neal, Gerber, & Eisenberg	Union Organization	73,117
See PG21A	Professional Fees	19,233
Note Clausen/Babayan Eliminated		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 848,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,104
Unemployment Compensation Insurance	30,696
FICA Taxes	222,375
Employee Health Insurance	60,845
Employee Meals	22,397
Illinois Municipal Retirement Fund (IMRF)*	
Mktg Manager Benefit Deduction	(12,538)
Dental, Life	1,218
Emp Relations, Misc	3,297
Tuition Reim, Drug Test, 401K, Vaccinations	3,560
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,955

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	876
Health Care Worker Background Check	
(Indicate # of checks performed 7)	74
II Health Care Assoc	3,440
Surety Bond Fee	350
Related party - AMS	276
11 Street Express / Jewish News	770
Chicago SunTimes	183
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto/Gas	2,677
Related Party-AMS	7,654
Seminar Expense	
Training Reimbursement	419
Deming Seminar	1,250
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,000

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

C. Professional Services Continued

Vendor/Payee	Type	Amount
Cambridge	Financing Fees	14,269.13
AMS	Professional Fees	666.67
Neil, Gerber, & Eisenberg	SEIU Conference Calls	107.90
Medicom	Billing Consulting	189.24
Urban Real Estate Research	RE Assessment Fee	4,000.00
C. Professional Services Continued to PG21		**19,233**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	painting>$1500 for 2000	7/00	$ 2,176	3	$ 725	$ 363	$ 0	$	$	$	$	$	$
2	GT Mechanical-repair hot	10/03	2,258	3		188	753	753	564	0	0		
3	ABC-repair water booster	6/03	2,209	3		429	736	736	308	0	0		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,643		$ 725	$ 980	$ 1,489	$ 1,489	$ 872	$	$	$	$

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC **#** 0042028 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL Health Care Assoc-$5,134**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **14,403** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ **50,919**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **22,397** Has any meal income been offset against
related costs? **None** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain. **Not Required**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.